Peninsula Health

REFERRAL
INTEGRATED PAIN SERVICE

FAX: 9125 5862

PHONE: 1300 665 781

UR NUMBER .....

SURNAME .....

GIVEN NAMES .....

DATE OF BIRTH .....

Please fill in if no Patient Label available

App.5/10/2023 Print Code:17541

PHF3532200)

Attention: Head of Unit - Dr T. Weaver

Client Details:

Client Name: ..... Date of Birth: ...../...../.....

Address: .....

Telephone – Home: ..... Mobile: ..... Work: .....

e-Mail: .....

Financial Status: ☐ Worksafe ☐ TAC ☐ DVA ☐ Public Medicare No. .....

General Practitioner Details:

Name: ..... Phone: ..... Fax: .....

Address: .....

Primary Clinical Concern:

☐ Disabling pain (please state duration): .....

☐ Complex Regional Pain Syndrome (please state duration): .....

☐ Shingles or Post Herpetic Neuralgia ☐ Cancer Pain ☐ Other (please describe): .....

Reason For Referral and Pain History:

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Past Medical / Surgical History:

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Are there any 'Red Flag' Symptoms / Signs:

☐ Fevers / Chills / Systemic Illness / Weight loss

☐ Age >60 or <20yrs

☐ Signs of Neurological involvement

☐ Trauma (minor trauma in elderly)

☐ IV Drug use

Are there any issues with communication, cognition or behaviour? ☐ No ☐ Yes

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It is mandatory that you include copies of relevant correspondence, medical reports, x-ray reports, pathology reports and a list of current and past medications for this referral to progress.

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Signature Print Name Provider No. Date

Please provide referrer details if not GP - Name: ..... Role/Specialty: .....

Phone: ..... Fax: .....

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MR/353200